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Safety of female patients in sexually-integrated acute
psychiatric wards in Aotearoa New Zealand

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Abstract

This qualitative study researched the experiences of seven women and one man who have either been admitted to, or worked in, a mixed-sex psychiatric ward in Aotearoa New Zealand. Its purpose was to examine the safety of female patients in sexually-integrated acute psychiatric wards.

There is only a small amount of international literature on this subject and even less from Aotearoa New Zealand. This research gives the women ex-patients involved in the study a voice. As mental health workers, the nurses provide a perspective from the 'other side' which also paints a strong picture of life for women patients in a mixed-sex psychiatric ward.

Only one of the ex-patient participants had experienced both a single-sex and a mixed-sex ward and was able to make a comparison between the two. All ex-patient participants would have preferred a single-sex ward and spoke of events ranging from 'feeling uncomfortable' to being physically attacked by men in a mixed-sex ward. Several referred to the lack of privacy in sharing facilities with men. The treatment of female patients by some male staff was also seen as a problem by both ex-patients and staff participants.

The nurses and patients recount a number of stories in which female patients were raped, intimidated or had their privacy invaded by men on the ward. This research comes to focus on the fact that women patients in mixed-sex psychiatric wards are often not believed when they complain of being sexually/physically assaulted or harassed by men on the ward. I analyse this assertion from a feminist perspective and propose that at times, a gender bias operates which favours the claims of male patients over female patients. I conclude that sexually-integrated acute psychiatric wards are not necessarily a safe environment for female patients and suggest a physical (structural) change may be all that is required to ensure greater comfort and safety of female patients in psychiatric wards.

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Several forms relating to confidentiality and other ethical considerations in this study were not used, and therefore not indexed.

The terms 'sexually-integrated wards' and 'mixed-sex wards' are used interchangeably.

To maintain confidentiality, the names of specific hospitals will be replaced with xxxxxxxx.

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Chapter One

Introduction

I believe that when one is unwell, the environment in which one finds oneself becomes a significant factor in the ability to heal.

Being admitted to a psychiatric ward can be a traumatising experience for anyone. Central to this for some people is the reality of having to share accommodation and facilities with others who are often strangers, and with whom one may not necessarily choose to spend time. In mixed-sex wards men and women of diverse cultural, religious and social backgrounds are brought together in a relatively small physical environment. And just like the wider community that it resembles, mixed-sex wards contain both positive and negative aspects of human nature and behaviour.

For women, this can mean that the risk of physical and/or sexual abuse and/or harassment that exists on the 'outside' exists also in the mixed-sex ward and may even be greater. Given that those who are admitted to an acute psychiatric ward are often very unwell, the need for a safe environment is imperative. This thesis begins by asking whether a mixed-sex ward allows for a therapeutic environment in which women can begin to heal.

The literature shows that until the 1960s, mental health in-patient facilities in Aotearoa New Zealand were segregated by sex. Since then, and as part of an international trend, there has been a gradual phasing out of single-sex wards. Although written accounts of the arguments which drove this change in mental health service provision are minimal, what does exist demonstrates that this shift

was seen to be in line with the wider issue of moving away from institutional care and towards rehabilitation, more efficient use of hospital resources, and the positive impact mixed-sex wards have on male patients (refer chapter two).

I have also used in this thesis literature from the United States of America and Australia, but most of the information I have regarding mixed-sex psychiatric wards was written in the United Kingdom over the past twenty years and is the basis of chapter two, the literature review.

This literature suggests that the mixing of women and men in the same ward has been seen as a problem, particularly around the safety of women (Altounyan,1993; Warner,1994; Feinman,1988; McMillan,1992; Cohen,1992). Significant among these issues was the incidence of rape and physical assault. The United Kingdom literature noted multiple incidents of rape in mixed-sex psychiatric wards (Feinman,1988; McMillan,1992; Cohen,1992). One of the participants in this study also reports a sexual assault whilst residing in a mixed-sex psychiatric ward (refer chapter six).

The real rate of assault on female patients will no doubt be hard to determine. Those that are reported here in this study represent a few cases where the women felt able to speak out. Typically, psychiatric patients are among the most vulnerable in any society. The ability to speak out may be hindered by a number of factors leaving us unaware of the real issues that influence the environment that women find themselves in when needing acute mental health in-patient services.

The issue of women's safety in mental health services in Aotearoa New Zealand was also a concern of some since de-segregation. In 1989 the Mental Health Foundation of Aotearoa New Zealand established a Patient Advocacy Service. This provided a forum for patients to express their concerns. In 1991 the service

raised concerns about the safety of female patients. The issues of fear, safety and sexual assault on female patients in mixed-sex psychiatric wards in Aotearoa New Zealand was subsequently discussed in a 1992 report titled 'Safety of Women in Mental Health Services' produced by the Auckland Area Health Board. This document was the only local one I could locate on this topic and I was driven by this lack of information and discussion. I could find no accounts of mixed-sex wards by women patients themselves in this country, nor could I find any documented discussion on the motivation behind mixing of sexes in psychiatric wards in Aotearoa New Zealand.

In my methodology section (chapter three), I have critiqued positivism from a feminist perspective. Thus this chapter 'Perspective and Methodology' provides an overview of feminist epistemology, research theory, methods and methodology. Within this I draw from the works of Harding (1986,1989), Bunkle (1992), Reinharz (1992), Stanley (1983) and Oakley (1981) among others. The link between scientific rationalism and gender is discussed, as is the intention of feminist research to minimise the power imbalance that exists between researched and researcher. The methodological orientation and corresponding research methods used in feminist research are guided by the principles of feminist theory. Essentially, feminist research seeks to identify that which subordinates women to men. At the same time however, feminist research acknowledges the multiple realities of women (Smith and Nobel-Spruell,1986, Reinharz, 1992, Wise, 1990).

The second part of chapter three outlines my own process in gathering data for this study. I interviewed four women ex-patients and three women and one male nurse. All but one identified as Pakeha. One identified as both Maori and Pakeha. I sent verbatim copies of the transcripts to all the participants who had requested this. No alterations were requested or made. The ex-patient sample was purposive in that I needed women who had been in a mixed-sex psychiatric

ward in Aotearoa New Zealand. I conducted all interviews and transcribed all the tapes myself. I analysed the data collected from the interviews using a process of content analysis.

Chapter four provides selections from the transcripts of the nurses. This data fell into two categories: 'on the change from single to mixed-sex wards'; and 'on the safety of women patients'. Three of the nurses described how they were opposed to mixed-sex wards in terms of the dangers for women patients. The fourth had mixed feelings noting the vulnerability of women on the one hand but the normalisation of the environment on the other. Some of the nurses went on to describe incidents that put women patients at risk of serious harm (including rape) that they had witnessed. Others mentioned the inappropriateness of placing male rapists with sexually victimised women patients in close sleeping proximity.

Three themes emerged in chapter five from the data provided by the ex-patients. Privacy and 'space invasion', 'safety and comfort', and, 'on being lesbian'. All the ex-patient participants said that they had felt unsafe on a mixed-sex ward. Each had a story to tell. Some also had negative experiences with male staff. A male staff member sexually assaulted one and the other had been intimidated, restrained and had her pants pulled down by male staff wanting to give her medication.

One of the things I was interested in with this group was whether or not they were told that they were going to be hospitalised with men. None of them were informed, but being extremely unwell, none of them cared much at the time. They all did come to care at some point however. One even ran away to get away from the men. Others described a lack of privacy at having men sleeping in close proximity to women with only curtains separating them, of men being able to observe them in the showers and of being unable to lock shower or toilet

doors. Another spoke of her fear of male patients in psychiatric hospitals first because she was so young, secondly, she felt that whether true or not, her perception was that the hospital was full of sexual predators. Thirdly, this woman witnessed a lot of violence at various institutions over time, none of which was carried out by women.

Standing out for me from the international literature, the Auckland Area Health Board document and the transcripts was the issue of women patients not being believed when they alleged physical or sexual harassment/assault. Indeed, often such allegations have been dismissed as being 'part of her *illness*'. At the same time however, male patients are sometimes excused of abusive behaviour because it was 'part of *his* illness'.

In chapter six I ask what causes this gender bias that sees women often not being believed? and attempt to answer with a feminist analysis of women and mental health. This chapter begins with an overview of women's vulnerability to sexual assault in general, then focuses specifically on how this risk is increased in a mixed-sex psychiatric ward. I then look at the classification and treatment of women who are (seen to be) mentally unwell since the Victorian era in Western society. Within this, I draw mainly from the work of Valerie Ussher (1991), Phyllis Chesler (1997) and Elaine Showalter (1985) and discuss female sexuality and deviance; women, madness and social control; and the controversial treatments of moral management and surgical genital mutilation.

Concluding on a more contemporary note, chapter six also looks at work that suggests some mental illness diagnoses are gender biased. Unipolar depression for instance is diagnosed in twice as many women as men. In this section, I refer to two studies that claim that clinicians view female patients differently from male patients, with the behaviour of the latter being more highly valued than the former.

In the seventh chapter I challenge the notion of 'normalisation' in a sexually-integrated psychiatric ward environment, and whether the attainment of such creates a therapeutic environment for women patients. I conclude with a recommendation for structural changes which would create safer wards for women patients, and finally, identify unanswered questions and possible next steps for further research.